GREGSON & ASSOCIATES DENTISTRY

DENTAL HISTORY

JEFFREY GREGSON, DDS

INFORMATION

Name (Full) _____ Birthdate _____

FIRST NAME / MIDDLE INITIAL / LAST NAME — MM / DD / YYYY

PREVIOUS PHYSICIAN AND/OR SPECIALTY PHYSICIAN

PREVIOUS DENTIST _____ TREATMENT (OTHER THAN A CLEANING) ____/____/____

DATE OF MOST RECENT DENTAL EXAM ____/____/____ X-RAYS ____/____/____

I ROUTINELY SEE MY DENTIST EVERY ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not Routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY

	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) 1 2 3 4 5 6 7 8 9 10		
2. Have you had an unfavorable dental experience?		
3. Have you ever had complications from past dental treatment?		
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?		
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, if yes, at what age? _____		
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma		

GUM AND BONE

	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?		
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?		
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?		
10. Is there anyone with a history of periodontal disease in your family?		
11. Have you ever experienced gum recession or can you see more of the roots of your teeth?		
12. Have you ever had any teeth become loose on their own (without an injury) or feel them move when chewing?		
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?		

TOOTH STRUCTURE

	YES	NO
14. Have you had any cavities within the past 3 years?		
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?		
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?		
18. Do you have grooves or notches on your teeth near the gum line?		
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		
20. Do you frequently get food caught between any teeth?		

BITE AND JAW JOINT

	YES	NO
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?		
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?		
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?		
25. Are your teeth becoming more crooked, crowded, or overlapped?		
26. Are your teeth developing spaces or becoming more loose?		
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?		
28. Do you place your tongue between your teeth or close your teeth against your tongue?		
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?		
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		
32. Do you wear or have you ever worn a bite appliance?		

SMILE CHARACTERISTICS

	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?		
34. Have you ever bleached (whitened) your teeth?		
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?		
36. Have you been disappointed with the appearance of previous dental work?		

OTHER _____

Patient's Signature _____ Date _____

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